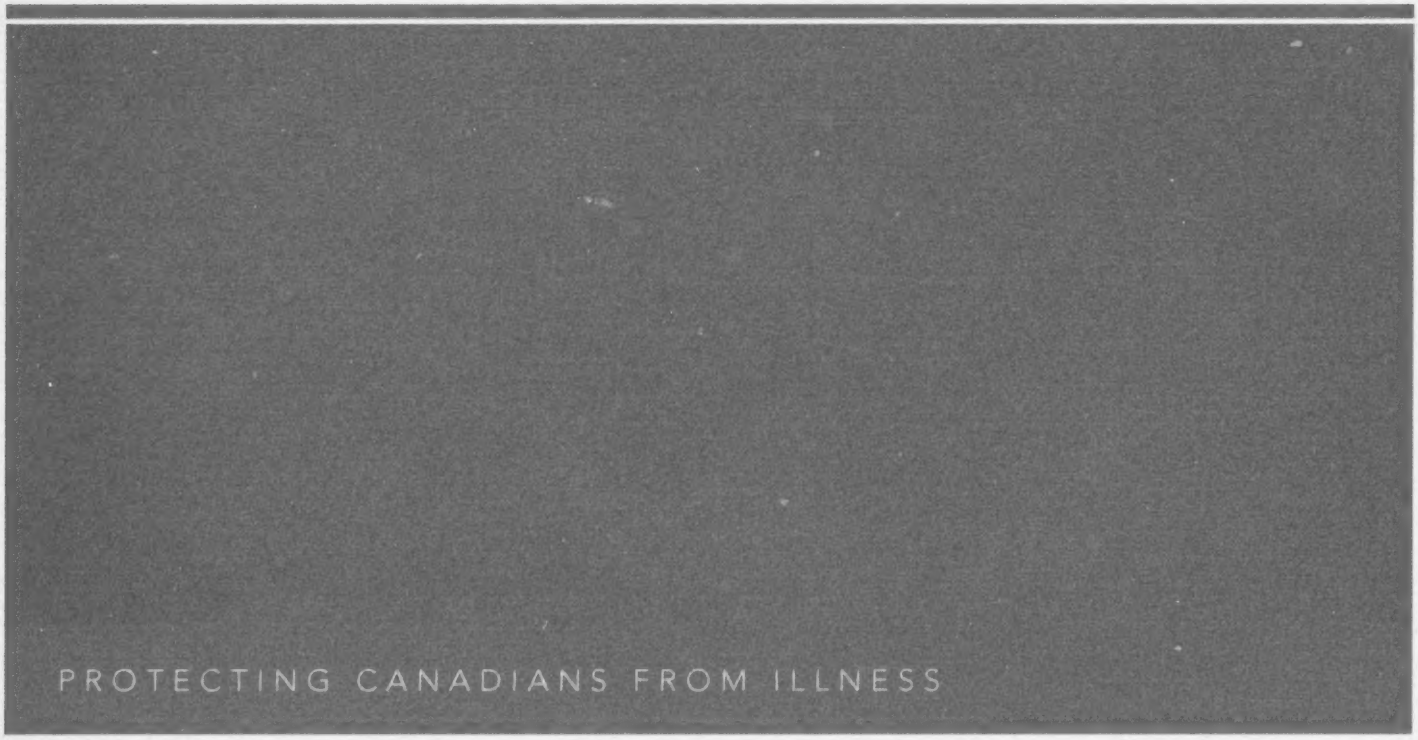
WAYS TRIED AND TRUE

ABORIGINAL METHODOLOGICAL FRAMEWORK FOR THE CANADIAN BEST PRACTICES INITIATIVE



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1. INTRODUCTION

The aim of this project is to present a culturally relevant and inclusive framework with which to identify and systematically assess Aboriginal health[1] promotion and chronic disease prevention interventions for inclusion on the *Aboriginal Ways Tried and True* (WTT) section of the Public Health Agency of Canada's Canadian Best Practices Portal (the Portal). With the WTT Framework, the Public Health Agency of Canada (the Agency) seeks to overcome challenges that have prevented the proliferation of Aboriginal interventions on the Portal to date, by using a culturally congruent and academically rigorous methodology. The rubric assessment structure put forward in the WTT Framework is based on factors associated with successful public health interventions in First Nations, Inuit and Métis settings. It is truly grounded in *Aboriginal Ways Tried and True*.

The current *Ways Tried and True*: Aboriginal Framework (WTT Framework) was shaped by: 1) input from the expert working group; 2) Aboriginal community-based health practitioners and researchers (totaling 82 professionals); and 3) a review of the literature. The WTT Working Group, spanning two phases and consisting of a total of over 20 different members with diverse expertise in Aboriginal health and evidence-based research, has been a pivotal and active partner in all aspects of the project (See Appendix A for a list of members), including identifying focus areas and troubleshooting issues with the existing intervention assessment and selection criteria. Expertise was also given by several other contributors regarding specific topic areas (see also Appendix A).

The interventions included on the Portal as a result of this WTT Framework, are intended to inspire and support public health practitioners, program developers, evaluators and others by sharing information on programs and processes that have been successful in Aboriginal contexts. Given the great diversity of Aboriginal communities, peoples and cultures, it is not expected that any one intervention will work for all communities. However, it is hoped that in sharing examples from specific contexts, the lessons learned will benefit others developing new initiatives. Similarly, as new initiatives are shared, the WTT Framework will grow and change, as it is adapted to include new ideas, information and perspectives.

[1] In this document, the term Aboriginal refers to First Nations, Métis and Inuit communities. Despite this use of an overarching designation, it is important to recognize that there is great variation between and within these communities.

2. PROJECT RATIONALE: ESTABLISHING THE NEED FOR A NEW APPROACH

The health disparities between Aboriginal and non-Aboriginal Canadians are well-documented (Reading, n.d; First Nations Information Governance Committee, 2012; Health Council of Canada, 2005). Yet information on how best to address these inequities and improve health and well-being is difficult to find.

The Agency's Portal is a Canadian forum through which best practices in health promotion and prevention interventions are shared, yet there are few Aboriginal examples on the Portal. In November 2013, there were 374 interventions listed on the Portal. Of these, 23 (6%) were Aboriginal-specific interventions or adaptations of mainstream interventions used in Aboriginal contexts.

The Agency has tried to bolster the number of Aboriginal-specific interventions listed on the Portal, but it has proved difficult to identify and screen-in new public health interventions using the Portal's current criteria structure. The lack of evaluation data and/or unavailability of evaluation data that meets Portal criteria have been a substantial barrier to the inclusion of Aboriginal interventions on the Portal (Stone Circle Consulting, 2010).

In the sections that follow we explore the need for a new approach to assessing interventions that have been successful in Aboriginal contexts. The challenges in research and evaluation are explored, as is the current literature on what constitutes "best practice" in Aboriginal settings. The discussion culminates in the presentation of a new approach to the identification and assessment of public health interventions in Aboriginal contexts.

2.1 A Brief Look at Evaluation and Research in Aboriginal Contexts

We know that excellent public health programs are occurring in Aboriginal communities; however, there are a number of factors that may prevent these interventions from meeting the Agency's current Portal evaluation criteria. Summarizing Saini's (2013) work, the National Collaborating Centre for Aboriginal Health (NCCAH) describes inherent differences between Aboriginal and Western research values:

> "WESTERN RESEARCH TENDS TO VALUE SYSTEMATIC METHODS THAT CAN BE REPLICATED AND TESTED BY OTHER RESEARCHERS. VALIDITY IN THIS CONTEXT OFTEN MEANS PROVING THAT RESULTS ARE CONSISTENT, RELIABLE AND NOT INFLUENCED BY EXTERNAL VARIABLES. IN CONTRAST, ABORIGINAL RESEARCH TENDS TO VALUE METHODS THAT INVOLVE COMMUNITIES AND PRIORITIZE JUSTICE AND ACTION (NCCAH, N.D.)."

Further, highly-valued Western research designs do not incorporate Aboriginal research values. For example, researchers have failed to integrate a cultural approach into randomized control trials, limiting the application of this "gold standard" method in Aboriginal contexts in

spite of the need for the type of data that this method produces (Saini & Quinn, 2013).

The challenges in integrating Aboriginal values into mainstream practices also extend to the field of evaluation. Chouinard and Cousins (2007) report significant challenges with implementing culturally sensitive evaluations, including lack of resources to engage participatory approaches and incongruence between culturally sensitive approaches and evaluation funder criteria. A definitive set of best practices in Aboriginal evaluation has not been developed; however, academics and practitioners (Van der Woerd, 2010; Chouinard & Cousins, 2007; Fetterman & Wandersman, 2004) have begun to highlight attributes associated with successful evaluation of Aboriginal programming, such as including cultural sensitivity and context. Collaborative, Participatory, and Empowerment (CP&E) evaluation is also a notable methodology.[2]

Accessing evaluation data can also be difficult, despite high levels of accountability through reporting requirements, particularly for federally funded programs. Evaluations are typically provided to funders, and may not be shared publicly through typical channels such as academic publications or gray literature; evaluation is typically underfunded, limiting the methodological depth; or evaluation may not reflect the community's evaluation needs. Further, many successful interventions originate out of need, and outcomes may be obvious to the community but not validated through evaluation, due to a lack of resources or low priority given to evaluation.

This data scarcity and lack of publication presents a challenge to identifying public health interventions implemented in Aboriginal settings.

2.2 Western vs. Aboriginal Concepts of Best Practice

The Agency defines best practices as:

> "INTERVENTIONS, PROGRAMS OR INITIATIVES THAT HAVE, THROUGH MULTIPLE IMPLEMENTATIONS, DEMONSTRATED HIGH IMPACT (POSITIVE CHANGES RELATED TO THE DESIRED GOALS), HIGH ADAPTABILITY (SUCCESSFUL ADAPTATION AND TRANSFERABILITY TO DIFFERENT SETTINGS), AND A HIGH QUALITY OF EVIDENCE (EXCELLENT QUALITY OF RESEARCH/EVALUATION METHODOLOGY, CONFIRMING THE INTERVENTION'S HIGH IMPACT AND ADAPTABILITY EVIDENCE)."

Understanding "Best Practices" from an Aboriginal Perspective

Use of the term "best practices" in Aboriginal contexts is evolving and controversial (Aboriginal Healing Foundation, 2006; Legacy of Hope Foundation, 2011). While the National Aboriginal Health Organization (NAHO) has used the term "best practice," describing it as a "moving target" (as cited in Marriott & Mabel, 2001, p.21), others prefer to use "promising practice", "good practice", or "wise practice" (Canadian Aboriginal AIDS Network, 2005; Aboriginal Healing Foundation, 2006; Health Council of Canada, 2011; Legacy of Hope Foundation, 2011).

The Canadian Aboriginal AIDS Network (CAAN) describes a number of challenges with the

[2] Collaborative, Participatory, and Empowerment (CP&E) Evaluation is an American Evaluation Association Topical Interest Group supported by experts such as Dr. David Fetterman, comprising one quarter of the total AEA membership. See http://comm.eval.org/cpetig/home (accessed May 24, 2014).

general concept of best practice in an Aboriginal context, concluding: "such a model is inappropriate to programming in the variety of unique cultural and situational environments that characterize Aboriginal communities" (2004, p.3). From an Aboriginal perspective, the primary challenge is the replication component, which implies that a specific intervention or approach will work in all settings. The idea of replication is at odds with common colloquial knowledge as well as academic evidence that calls for solutions to be strongly based on context (White Feather Elders, personal communication with Andrea L. K. Johnson, August 14, 2013; Aboriginal Healing Foundation, 2006; CAAN, 2005; Gone, 2008; Barron, 2009; Indian and Northern Affairs Canada, 2009; Brown et al., 2010; Reading, Kmetic & Gideon, 2007; Loppie Reading & Wein, 2009; Marriot & Mabel, 2001; Smylie et al., 2003; Legacy of Hope Foundation, 2011). A related apprehension with the term is that once an intervention is labelled as a "best practice", funders may only fund "best practice" interventions, without regard for local priorities and context (Interview Participant).

Also absent from the Western definition of best practice, yet central in Aboriginal contexts, is process. As discussed above in relation to research and evaluation, how the research is conducted within the community plays an important role in the quality of evidence. We argue that the same is true in the development and implementation of public health interventions. That is, interventions that are strongly rooted in the community context and which follow community protocol will be more effective than those that do not. In the words of one interview participant: "if you understand the community, your intervention will tend to work."

A New Term: "Ways Tried and True"

Knowing that the term "best practice" could not be used, there was a need to identify new terminology. Originally "good practice" was considered; however, this term is also problematic because it denotes a lower value than a best practice. In speaking about the issue with Traditional Ojibwe Kokomis/Teacher Jacqui Lavalley[3], the term *"Ways Tried and True"* was suggested.

The rationale Kokomis Lavalley provided is:

> "THE SHARING OF THE EFFORTS MADE BY THE PROGRAMS AND INITIATIVES WE PROPOSE TO EXAMINE NEEDS TO BE ABOUT UNDERSTANDING THE ACT OF DOING AND NOT ABOUT DOCUMENTING WHAT HAS BEEN DONE OR IS ANTICIPATED TO BE COMPLETED IN THE FUTURE. IF WE WERE TO SPEAK TO THE PEOPLE IN THE COMMUNITIES THEY WOULD BE ABLE TO SPEAK ABOUT THE WORK THEY ARE DOING. IT IS THE ACT OF DOING WE WANT TO CAPTURE. THE ANISHNAWBE LANGUAGE EXPRESSES SOMETHING THAT IS HAPPENING; EACH WORD IS A WHOLE STORY. WHEN WE SPEAK THE LANGUAGES WE DO IT WITH PRIDE KNOWING WE ARE DOING IT THE BEST WAY WE CAN, AND WE DO IT WITH A LOT OF HUMOUR. WHEN WE WERE TAKEN AND SENT TO RESIDENTIAL SCHOOL WE WERE TOLD NOT TO SPEAK THE LANGUAGES, BUT THEY COULD NOT TAKE FROM OUR MINDS THE WAY WE SEE

[3] Jacqui Lavalley, Chippewas of Nawash, 2nd Degree Medawin, Raised-up in 1996 as Kokomis at Native Canadian Center of Toronto.

THE WORLD. THE WORLD IS ACTIVE – IT IS THIS ACTIVE TENSE WE NEED TO CAPTURE. *WAYS TRIED AND TRUE* SPEAKS OF WHAT WE VALUE AS MEETING OUR STANDARDS, AND SPEAKS TO OTHERS OF KNOWLEDGE THEY CAN TRUST AND RESPECT."

3. FOUNDATION AND METHODOLOGY OF THE WTT FRAMEWORK

3.1 Our Conceptual Model for Aboriginal Wellness

In the discussion below, we highlight the definition of health and wellness used as the basis for the *Ways Tried and True* (WTT) Framework. We also examine the link between Aboriginal concepts of wellness and research. These concepts address health and wellness gaps that exist within Aboriginal groups and between Aboriginal and non-Aboriginal Canadians.

Aboriginal groups in Canada are diverse, and while there is no singular definition of Aboriginal wellness there are several commonalities in health perspectives. For instance, many Aboriginal groups view health as not merely the absence of disease, as is emphasized in bio-medical models, but as the balance and interconnectedness in health and well-being of spirit, mind, (emotion) and body with individual, (family), community and environment (Ootoova et al., 2001; Edge & McCallum, 2006).

The Ojibwe phrase "*Mino-Bimaadiziwin*" or "Healthy Way of Life" describes this balance:

> "ONE MUST ALWAYS BE AWARE OF THE INTERRELATIONSHIP BETWEEN ALL BEINGS TO ENSURE *MINO-BIMAADIZIWIN*, THE HEALTHY WAY OF LIFE. THIS INCLUDES BALANCING ONE'S RELATIONSHIPS WITH THE SURROUNDING ENVIRONMENT, SURROUNDING BEINGS, AND THE INNER PHYSICAL, EMOTIONAL, INTELLECTUAL AND SPIRITUAL NEEDS OF THE HUMAN CONDITION (OJIBWE.ORG)."

When an individual or community is out of balance, ill health can arise. Maintaining balance in one's life is the most important factor in maintaining optimum health and preventing disease.

The history and experience of colonization has played a devastating role in upsetting this balance, making *Mino-Bimaadiziwin* a difficult goal for some First Nations, Inuit, and Métis to reach. Colonization and public policy resulted in the loss of self–determination and the systematic devaluation of culture and tradition. Indian Residential Schools inflicted trauma (psychological, physical, emotional and spiritual) on individuals, families and communities, and its effects are manifested at all of those levels persisting to the present day (Barron, 2009).

Mino-Bimaadiziwin bears some resemblance to the social determinants of health (SDOH) approach, which helps to conceptualize the links between sociopolitical factors and inequities in health status. Poor education, poverty, inadequate housing, food insecurity and social isolation have been linked to long-term stress implicated in specific conditions such as cardiovascular disease, diabetes, mental-illness and suicide (Minore & Katt, 2007; White & Jodoin, 2007; Bombay, Matheson & Anisman, 2009; Mikkonen & Raphael, 2010). For example, a recent study finds that poverty (acute or long term) can impair one's ability to make sound decisions (Mani, Mullainathan, Shafir & Zhao, 2013). Loppie Reading and Wein (2009) point to a progressive nature in the perpetuation of the social determinants. For instance, poor housing is linked to domestic violence and injury. Injury may result in disability which could exacerbate poverty, social exclusion and a number of other determinants (Minore & Katt, 2007; White & Jodoin, 2007; Mikkonen & Raphael, 2010).

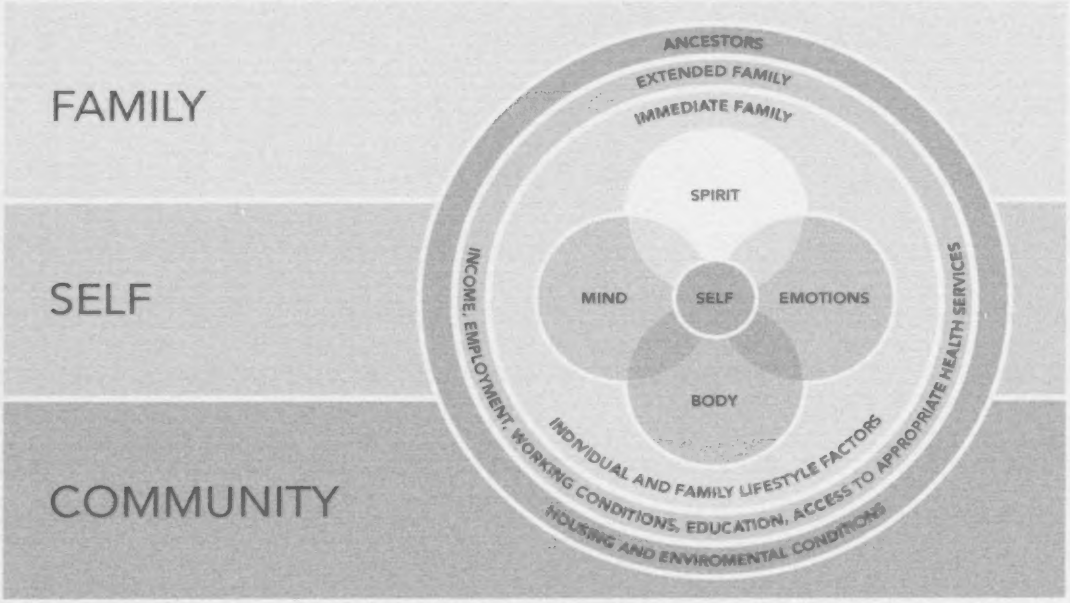
The literature also points to the importance of resilience, or the development of protective factors for health promotion and illness prevention. What creates resilience in individuals is still not fully understood, but resilience is seen as a key buffer against health risk factors (McIvor, Napolean & Dickie, 2009). Strong connections with culture, language and spirituality have all been shown to act as protective factors for wellness (Chandler and Lalonde, 1998, 2006; McIvor, Napolean & Dickie, 2009). The degree of social capital and social cohesion in communities has also been cited as a critical component of health in Aboriginal communities, re-emphasizing the traditional beliefs that the interconnection of individual, family and community are vital to balance and wellness (Barron, 2009; Fleming & Ledogar, 2008).

For Inuit, the SDOH may be different than for Aboriginal peoples in the rest of Canada. Specifically, food security has been identified as a primary social determinant of health, and barriers to food security are linked to historical displacements. More recently, climate change has affected the SDOH for this group (Inuit Tapiriit Kanatami, 2007).

Figure 1 below, *Our Wholistic Model of Aboriginal Health*, exemplifies the interconnectedness understood through *Mino-Bimaadziwin*, as discussed above. The Self is reflected both in the centre of the concentric circles and in-between family and community. The concentric circles reflect relationships between three domains: Family, Self, and Community. The central domain, Self, exists within four interconnected spheres, which by their depiction, continually interact in-and-out of a balanced state. This personal struggle for balance within Self also interacts externally within the domain of Family negotiating and honouring relationships within immediate family, extended family, and one's ancestors. The Self also interacts within Family units, in the Community domain. Concepts encompassing Community are divided by social determinants of health (SDOH). Individual and Family lifestyle factors align with the Immediate Family sub-set, where a person struggles for self-identity within the context of family lifestyles, either making conscious choices, seeking improved well-being or being stagnant which reflect wellness.

Income, Employment, Working Conditions, Education, and Access to Appropriate Health Services align with the Extended Family sub-set; where a larger community membership interacts with the Self and Family as their Lifestyle Factors are further influenced, either by conscious choice or through their inability either internal and/or external to pursue a path towards wellness. Finally, Housing and Environmental Conditions align with ancestors, where Self is challenged with correcting the choices made in the past by his/her ancestors, and acting to contribute and/or build a community where housing and environmental conditions flourish. This final sub-set also interacts with Family and Community towards supportive environments and/or further jeopardizing the livelihood of Aboriginal peoples to come through the next Seven Generations – at which point our choices today will be written as the poor or stellar choices of the ancestors.

FIGURE 1: *Our Wholistic Model of Aboriginal Health*



3.2 Developing the WTT Framework

The priority for the Agency, the WTT Working Group, and Johnston Research Inc. (JRI) was to develop an Aboriginal framework that is rooted in both scientific and cultural evidence, in order to generate an assessment process that achieves evaluation rigour while still being inclusive of First Nations, Inuit, and Métis interventions. Section 2 laid the foundation of evidence upon which the WTT Framework is built. From a methodological perspective this project can be divided into two phases: (1) framework development phase and (2) framework validation phase.

WTT Framework Development Phase

The WTT framework was developed in partnership with project authorities at the Agency and the Working Group (WTT Working Group) (Appendix A); and in consultation with the WTT Working Group; interviews with Aboriginal health experts identified by the WTT Working Group and focused special topic literature reviews.

Consultation with the WTT Working Group

The WTT Working Group is made up of health professionals based in government or Aboriginal organizations. This work was initiated with a face to face meeting held in Ottawa in July 2013. This meeting was pivotal for helping to set the priorities and direction for the WTT Framework overall.

Subsequent WTT Working Group meetings were held by teleconference on a monthly basis, to support the development of the WTT Framework.

Interviews with Aboriginal Health Experts

Telephone interviews with 11 Aboriginal health experts identified by the WTT Working Group were conducted between July 29, 2013 and August 16, 2013 (for a list of interviewees see Appendix D). The interviews focused on building consensus on the WTT Framework including concepts of Aboriginal Health, agreement with topical focus, and engaging with communities (for a copy of the interview guide see Appendix E). Data from the telephone interviews was synthesized with the literature data and data from WTT Working Group meetings.

Focused Literature Reviews

Focused literature reviews on the following topics were completed to inform the WTT Framework: best practice in an Aboriginal context, health priorities of National Aboriginal organizations, and Aboriginal concepts of health.

4. FINDING A COMMON GROUND: IDENTIFYING WHAT WORKS IN ABORIGINAL CONTEXTS

Based on the evidence presented above, we conclude that Aboriginal interventions may be excluded under the Agency's current criteria, for a number of reasons related to differences in research and evaluation values, lack of evaluation data and differences associated with the concept of best practice. Aboriginal researchers have identified process characteristics associated with good practice.

There is some agreement in the literature on factors that make for promising practices in Aboriginal health and healing contexts, although it should be noted that these factors come from descriptions of processes, rather than documented outcomes (see evaluation discussion in 3.1 above). The general implication is that if the processes are implemented, positive outcomes will follow.

Several organizations have identified interventions that have shown promise in Aboriginal settings, yet we are aware of no organization that has identified a comprehensive set of criteria or a systematic approach for assessing outcomes and process. In all of the examples we found, communities/organizations were asked to submit interventions and practices they considered to be promising, and researchers identified characteristics of promising practice based on these submissions (see Appendix D). The process used by each of these organizations is briefly described below:

- In 2013, Aboriginal researcher Kim Scott and the National Collaborating Centre for Aboriginal Health identified "Promising Practices to Strengthen Urban Aboriginal Families in Canada." The authors recognized that practice is highly dependent on context and used the following criteria to select projects for case study analysis: joint decision making with Aboriginal families; provision of culturally appropriate services; addressing jurisdictional barriers; centralized service integration; the production of desired outcomes, and adaptability.
- In 2011, the Health Council of Canada (HCC) published a Compendium of Promising Practices related to Aboriginal Maternal and Child health. The report identified 22 "promising" initiatives, strategies, policies and organizations. Initiatives were included on the basis of self-selection or recommendation provided that they:
  - positively advanced Aboriginal health status;
  - included the interests and experiences of many;
  - were valued and supported by relevant stakeholders;
  - were well-known with a history of success;
  - were adaptive, recognizing community context; and
  - were, ideally, evaluated.

Application of these criteria appears to have been fairly informal.

- In 2006, the Aboriginal Healing Foundation (AHF) published a report identifying a number of promising healing practices in Aboriginal communities. Similar to HCC's work, the programs were identified through self-selection; that is, communities/organizations volunteered to have their program included in the report. All submitted initiatives were included.[4] Key stakeholders were solicited to suggest case studies.
- A number of web sites including McMaster's healthevidence.org and the HCC Health Innovation Portal also include Aboriginal interventions, but are not considered here because the focus is not specific to Aboriginal contexts.

A review of the literature on Aboriginal-specific "best practices," "promising practices" and "wise practices" was conducted. Seven specific reports (Scott, 2013; JRI, 2012; HCC, 2011; Smith et al., 2010; AHF, 2006; CAAN, 2004; Marriot & Mabel, 2001) that defined success in an Aboriginal health context were predominantly used. A synopsis of this literature is provided in Appendix D. Each criteria identified in the reports was reviewed – those factors that were too specific to a particular health topic/intervention (i.e., AIDS, healing programs) were removed and the remaining concepts were grouped thematically to produce the following list of seven elements associated with good health practice in Aboriginal contexts: basis in the community; wholism; integration of Indigenous knowledge; builds on community strengths and needs; partnership and collaboration; sustainability; and effectiveness. These factors, with the exception of sustainability, form the basis of the assessment structure outlined in section 4.3. Sustainability was excluded as a criterion based on discussions with focus group participants and pilot testing. Several focus group participants indicated that sustainability was an unfair criterion given that communities have little control over whether an intervention is sustained. This criterion was also removed because a high level of variability observed among raters during the assessment process.

4.1 Operational Definition of Terms

While there is general agreement on the importance of these six basic concepts, less information is available on the operational definition of these terms. We have therefore developed operational definitions based on the literature and our experiences working in the field. These categories are not mutually exclusive; intervention elements are interconnected, consistent with the Aboriginal view of health and wellness, as described in section 3.1 below.

Community Based

In the context of the WTT Framework, the concept of community-based intervention is defined by the degree to which Aboriginal stakeholders (community members, service providers, community leaders, Elders) are involved in the identification of the need, planning, design, delivery, adaptation and evaluation of an intervention. A gold standard scenario is one in which an intervention is developed by the community (likely in partnership with others) based on an identified need or health priority.

The literature strongly supports locally driven interventions rooted in the context of community

[4] In 2011, working with the Legacy of Hope Foundation, the AHF followed up on this work with an in-depth study of ten community-based healing practices (Legacy of Hope Foundation, 2011)

(Reading et al., 2007; AHF, 2006; Marriot & Mabel, 2001). Interventions that are strongly based in the community and have a high level of buy-in are more likely to demonstrate success or to be adapted to ensure they work, because of a vested interest by the community (Barron, 2004).

To say that a program or intervention is community-based may mean different things to different people, and gradations exist in the level of involvement an Aboriginal community or other stakeholders may exhibit in bringing an intervention to life.

To be considered for *Ways Tried and True*, interventions must demonstrate involvement from community.

Wholistic Approach

The National Aboriginal Health Organization (NAHO) defined wholistic health care as "an integrative approach – that seeks to balance the mind, body, and spirit with community and environment" (NAHO, 2011). The idea of wholism is strongly related to the SDOH, and more generally to a population health approach, in that wholism naturally recognizes the multitude of factors (socio-economic status, education, family dynamics, and health of a community) at play in reaching a state of wellness or well-being.

While wholistic approaches are favored in both a cultural and academic sense, a common challenge experienced by communities and organizations in developing interventions that are wholistic is the division among funding streams, which can preclude broad level approaches to health and wellness (PHAC, 2013).

In the context of the WTT Framework, the concept of wholism is divided into four key dimensions and is organized after the WTT Wholistic Model of Aboriginal Health (see Section 3.1):

- Dimension 1: Wellness: mind (knowledge development, awareness, skills), body (physical activity, nutrition), emotion (relationships, healing), spirit (mental wellness, confidence, self-esteem, coping)
- Dimension 2: Implementation environments (e.g., school, community, home, workplace, businesses)
- Dimension 3: Nature of target groups participants (e.g., children, youth, Elders, families, community members or leaders)
- Dimension 4: Involvement of cross-sector department (e.g., education, health, governance, justice social services)

Wholism is assessed by the degree to which the intervention addresses each of these dimensions in a comprehensive way. The rationale for this approach is that interventions that are inclusive of these dimensions are more likely to be successful. Specifically, wholism should be demonstrated through process aspects that address multiple vantage points, including where the initiative takes place (is it a school-based intervention? if so, does it have a component for parents/families?) as well as the number/nature of stakeholders who are involved.

Integration of Indigenous Cultural Knowledge

The concept of integrating Indigenous cultural knowledge is similar to basis in the community but is more specific. Integration of Indigenous cultural knowledge is defined by the degree to which the intervention addresses and incorporates the values, culture, shared experiences and principles of the community or group in which it operates.

Indigenous cultural knowledge tells us about the values, culture, shared experiences and principles of a community (Alderete, 1996). Kirmayer, Brass, and Valaskakis (2009) (referring to Aboriginal traditions) posit that while rooted in the past, culture is not static, but changes and grows to respond to new ideas and new challenges.

Building on Community Strengths and Needs

Community development is the degree to which an intervention recognizes community capacity or readiness, identifies strengths and weaknesses within the implementation environment at the outset, and includes mechanisms to leverage strengths and fill gaps through the implementation process. Interventions that build on strengths and endeavor to address weaknesses are thought to be more effective (Barron, 2004). A WTT scenario is one in which a community-based program evolves, becoming an example for others as demonstrated through replication of the initiative in other Aboriginal communities.

Partnership and Collaboration

Partnership and collaboration is defined by the degree to which the intervention is supported within a community or organization (other departments or institutions) as well as by those external to the community (federal, provincial, municipal government, NGOs, other institutions). Often times the development of the partnerships and collaboration is related to the presence of a project champion and the ability of those leading the project to develop strong relationships. The emphasis, in this case, is on meaningful collaboration between partners aside from existing funding relationships. A WTT scenario is where multiple departments are working together and in collaboration with government/NGOs or other partners to deliver an intervention and a project champion(s) has been identified.

Numerous researchers and experts in the field of Aboriginal health discuss the importance of recognizing, valuing, and integrating "multiple ways of knowing" (Brant-Castellano, 2001; Dion-Stout and Kipling, 2001; Anderson, 2003; Smylie et al., 2003). Indigenous knowledge is an important component as are other types of knowledge. Arguably, these ways of knowing become integrated through a process of partnership and collaboration.

> "COLLABORATION DESCRIBES THE LONGER-TERM AND MORE DELIBERATE EFFORTS OF ORGANIZATIONS AND GROUPS TO UNDERTAKE NEW, JOINT ACTIVITIES. COLLABORATION, OR PARTNERSHIP DEVELOPMENT (THE TWO TERMS MEAN THE SAME), IS LABOUR INTENSIVE (LABONTE 2003, P. 24)."

While important in all contexts, partnership and collaboration bears particular significance in many Aboriginal settings as a result of jurisdictional and other historical barriers. The formation of a tripartite health plan between BC First Nations and the provincial and federal governments is lauded as a promising approach to bridging historical jurisdictional gaps as a mechanism to improving health and well-being (PHAC, 2013).

Effectiveness

For reasons discussed in depth in section 3.1, interventions that are successful in First Nations contexts might not always be evaluated, or may use alternative methods for evaluation. In the context of the WTT Framework, interventions must have reported positive outcomes (intended or unintended); however, the outcomes need not be demonstrated through a formal or standard evaluation.

Sufficient information must be available to establish the effectiveness of the intervention. Accepted quality of evidence includes: peer reviewed reports/journal articles, gray literature reports, internal reports, reports emphasizing lived experiences and using Aboriginal specific data collection methodologies including storytelling, talking circles, and testimonials. Digital stories in the form of videos, blogs and other formats will also be accepted as evidence.

In the context of the WTT Framework, effectiveness refers to the degree to which an intervention has achieved substantive or statistical significant positive intended and/or unintended outcomes among target groups. Targeted groups may be specific cohorts or population subsets (e.g., Elders, youth, teachers, etc.), whole communities, organizations, and or partners. No distinction is made between intended outcomes (outcomes that were anticipated at the outset of an intervention) and unintended outcomes; with the focus instead on positive effects.

Within the definition, both statistical and substantive significance receive equal treatment based on the premise that the methods favoured in Aboriginal contexts may not always be ones that produce statistical data and even when they do, statistical significance may not translate to practical significance. Substantive significance is both a: 1. qualitative (e.g., meaningful or important in advancing social justice and reaching an equitable society), and 2. quantitative interpretation of results (e.g., a mathematical calculation designed to enhance statistical tests of significance). Donald Campbell (1963) defined substantive significance as describing results which are meaningful or important in advancing social justice such as policy changes towards a utopian society. Weiss (2000: 300) provides an example of such a situation. Evaluation results, found to be statistically significant, could "...show little effect-or seriously unpleasant side-effects." In terms of the WTT Framework, the term substantive significance is applied broadly to mean more than the quantitative effect-size but to also include qualitative or practical considerations such as cultural, political, or economic significance. Stated another way the substantive significance refers to the degree to which the findings bear relevance within the community and context in which they are observed. The determination of substantive significance is inherently more subjective but is something that should be able to be judged with some accuracy by those experienced in Aboriginal health.

The nature of the outcomes also bears importance within the definition for effectiveness, with demonstration of outputs being the lowest level demonstration of effect, followed by demonstrated increases in knowledge or awareness, and culminating in behavior change (including personal or practice, organizational/systems and or policy).

A WTT standard would be a scenario in which an intervention has demonstrated significant (substantive or statistical) achievement of positive behavior change outcomes (e.g., changes in: personal or professional practice, organizational/systems, and/or policy) for the target group(s).

4.2 Applying and Validating the WTT Framework

Using the six criteria identified above, a rubric structure was developed to allow the systematic assessment of interventions. Use of this rubric will help to overcome current challenges to the inclusion of Aboriginal interventions on the Portal. The rubric is provided in Appendix B. A handbook has also been developed as a companion to the rubric.

WTT Framework Validation Phase

Framework validation activities took place between February and June 2014 and consisted of a number of internal and external activities including: pilot testing, establishing inter-rater reliability, and generating feedback on the WTT Framework from key stakeholders at a number of external engagement events.

The WTT Framework represents a significant departure from a strict academic approach to the assessment of best practice. It also represents a novel way to consider First Nations, Inuit and Métis public health interventions and uncovers systematic challenges with the application of Western assessment approaches in Aboriginal contexts. Given the uniqueness of this project and the potential sensitivity, the WTT Working Group and the Agency project authorities supported action to engage in an extensive engagement process. The validation strategy was expected to achieve four primary goals:

1. Generate and collect feedback from experts in the field to strengthen the assessment tools.
2. Share information on the Agency's Portal initiative and generate awareness about the *Ways Tried and True* project specifically.
3. Ensure relevance and credibility around the approach.
4. Assess and build consensus/buy-in around the assessment tools (screening tool and rubric).

Pilot Testing

This framework was pilot tested on 20 Aboriginal public health interventions. Interventions were identified using three processes: systematic review of the academic literature for discussions of interventions; review of websites and gray literature reports; and solicitation of the interventions among WTT Working Group contacts. The intervention selection process is described in detail in Section 4.1.

Establishing Inter-rater Reliability

Seven of 20 interventions were assessed with the screening and rubric tools by two independent reviewers. Variation in composite scores ranged from one to three points. Reliability differed by criteria. For example the "sustainability" criteria category demonstrated the lowest inter-rater reliability while "community-based," "partnership/collaboration" and "wholistic" criteria categories demonstrated the highest congruence among independent raters. Testing of inter-rater reliability was complicated by concurrent changes to the rubric which made it difficult to provide conclusive statements. For example, throughout the period of inter-rater assessment and since that time, adjustments continued to be made to the criteria. Study of inter-rater reliability could be the focus of future work. In the meantime, all interventions should be assessed using the rubric by two people.

In spite of efforts to objectively differentiate between rubric criteria and levels within each element, there is a level of subjectivity inherent in the criteria. As with any tool of this nature,

multiple reviewers may not produce the exact same rating of an intervention. A small difference (1-2 points) is expected between reviewers.

The Propel Centre for Population Health Impact will also complete an independent review of the assessment as is consistent with the Agency's process for all interventions included on the Portal.

External Engagement Events

Four external engagement sessions were held between February and June 2014. Generally these sessions were targeted to both share information about the WTT Framework and generate feedback to support improvements to the tools. Evaluations were completed following each of the events. Each of the engagement events is discussed below.

Fireside Chats: Ways Tried and True Webinar

On February 26, 2014 the Agency's Chronic Disease Interventions and Best Practices Division hosted a Fireside Chat in collaboration with CHNET-WORKS. The webinar was attended by an estimated 200 public health practitioners, planners, policy and decision-makers as well as other community stakeholders working to promote health and prevent disease in Aboriginal communities across Canada.

The goal of this meeting was to share information on the WTT Framework development process. The meeting was very well attended as noted by the CHNET-WORKS coordinator, providing an indication of the interest in work in this area.

Chronic Disease Prevention Alliance of Canada Conference: Ways Tried and True Workshop

On March 27, 2014, the Agency hosted a pre-conference workshop at CDPAC's annual conference. The workshop was attended by 37 people from an array of national and community-based organizations including: the Canadian Cancer Agency; Canadian Mental Health Association of Ontario; Correctional Service Canada; KTC Tribal Council; Kitigan Zibi Anishinbeg Algonquin First Nation; Kwanlin Dün First Nation; and others. Through this workshop participants were introduced to the WTT Framework and were asked to use the assessment tools to assess interventions. Overall evaluation and discussion transcripts reveal a positive regard for the rubric. Suggestions for improvement included improving the specificity of operational definitions for the criteria.

Pegasus Global Health Conference

On May 3, 2014, representatives from JRI presented at the Pegasus Global Health Conference to a group of 12 medical students, physicians, health and academic administrators. Participants were led through a similar case study process offered at the CDPAC conference. Evaluation findings were positive. Suggested improvements include: further clarification of criteria definitions, particularly the definition of the wholistic element. Several attendees noted potential applications in academic environments as a teaching tool.

Ways Tried and True Virtual Focus Group

One June 11, 2014 a virtual focus groups was held and was the last of the four planned validation events. The focus group was attended by 13 people; participants included a mix of Aboriginal academics, academics with expertise in Aboriginal health, evaluators, frontline service providers and policy makers. The working group and project authorities invited 28 people to attend the

event based on their specific expertise or involvement in Aboriginal health.

The discussion of the WTT Framework centred on three core questions:

1. Have the "right" criteria been identified?
2. Will this assessment structure enable us to be more inclusive of First Nations Inuit and Métis public health interventions?
3. Do you think we are likely to achieve a suitable balance between rigour and inclusion using the proposed approach?

Feedback from each of these meetings was incorporated into the WTT Framework as much as possible.

5. FUTURE WORK

This framework reflects a first step in both defining "good practice" and developing assessment criteria from an Indigenous perspective, and as such this work should be seen as highly developmental and open to new interpretations and reflections. Given the exploratory nature of this work, there are several areas where the Agency may want to strengthen the WTT Framework through future projects.

1. Review the WTT Framework structure in one year (2015/16) to determine how it is working and identify if it is meeting needs.
2. Monitor web traffic to the *Ways Tried and True* section of the Portal to measure use of this section of the site and anticipate communications needs.
3. Explore the idea of creating an Aboriginal-specific annotation file. An Aboriginal annotation file would emphasize the stories behind the interventions, lived experiences, factors of success, and lessons learned.
4. Examine the alignment of this work with other Aboriginal health initiatives including CIHR's pathway project as well as other potential applications (e.g., as a teaching tool).

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APPENDIX A: WAYS TRIED AND TRUE WORKING GROUP MEMBERS

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APPENDIX B: WAYS TRIED AND TRUE: ABORIGINAL ASSESSMENT RUBRIC FOR PUBLIC HEALTH INTERVENTIONS

CRITERIA	DEFINITION	1	2	3	4	MORE INFO REQUIRED
Criteria #1: **Community-based**	The degree to which First Nations, Inuit, Métis stakeholders (community members, service providers, community leaders, Elders) are involved in the planning, design, delivery, adaptation and evaluation of an intervention.	The idea for the intervention comes from outside of the community and is implemented with limited community[1] involvement (involves the community without formal structures such as a project committee).	Adaptation of a mainstream approach to an Aboriginal context, with structures (committees, preplanned community engagement meetings) involving the community in the adaptation.	The intervention is based on a need identified by the community and is led by community members, but rooting of the intervention within the systems of the community has not yet taken hold.	The intervention is based on a need identified by the community and a strong community process is established. For example, action taken from within the community to address the need and ownership of the intervention (e.g., design through to evaluation) is deeply-rooted within the systems of the community.	
Rationale/ Examples						

[1] Community refers broadly to a grouping of people and may include a First Nations reserve, an urban community, or a Métis or Inuit settlement

CRITERIA	DEFINITION	1	2	3	4	MORE INFO REQUIRED
Criteria #2: **Wholistic**	The degree to which an intervention addresses multiple issues from a wholistic approach on each of the following (4) dimensions: (1) **Wellness:** mind (knowledge development, awareness, skills), body (physical activity, nutrition), emotion (relationships, healing), spirit (mental wellness, confidence, self-esteem, coping) [e.g., medicine wheel model may be used] (2) **Implementation environments** (e.g., school, community, home, workplace, businesses) (3) **Nature of target group** (e.g., children, youth, Elders, families, community members or leaders, organizations) (4) **Involvement of cross sector departments** (e.g., education, health, governance, justice, social services)	The intervention is one dimensional (one target group, one activity, one partner) and has not engaged a wholistic perspective.	The intervention addresses a few dimensions but remains limited in terms of targeted implementation environment, view of wellness, involvement of community partners and participants.	The intervention is multi-dimensional has targeted multiple implementation environments, participant groups, departments in the community and is based on a wholistic view of health.	The intervention is wholistic, targeting numerous environments (school, home, work), and/or participant groups (children, Elders, families, community leaders), community departments and implements a wholistic view of health.	
Rationale/ Examples						
Criteria #3: **Integration of Indigenous Cultural Knowledge**	The degree to which the intervention formally addresses and incorporates the values, culture, shared experiences and principles of the community or group in which it operates.	Values, knowledge, culture and community perspectives play an informal role in the intervention (e.g., an articulated theory, process or structure has not been identified).	Indigenous knowledge has been used to adapt a mainstream approach using an articulated theory, process and/or structure; however not within a community participatory process.	Articulated structures (committees, focus groups, processes) are in place to ensure that Indigenous knowledge is applied to the intervention within a participatory process.	The values, culture, and perspectives of the community are integrated into and continue to inform all aspects of the intervention, from planning through to implementation.	
Rationale/ Examples						

CRITERIA	DEFINITION	1	2	3	4	MORE INFO REQUIRED
Criteria #4: **Building on Community Strengths and Needs**	The degree to which an intervention recognizes community capacity or readiness (identifying strengths and weaknesses within the implementation environment) at the outset, and builds-in mechanisms to leverage strengths and fill gaps through the implementation process.	Intervention shows informal acknowledgement of community strengths and needs (gaps). Capacity may be being built, but not among First Nations, Inuit or Métis peoples within the community.	Intervention design formally acknowledges and builds on strengths of First Nations, Inuit or Métis peoples. Members of these groups within the community are building limited skills and/or resources as a result of the intervention.	Intervention design acknowledges and builds on strengths of the community and attempts to fill gaps in community expertise, resources, services (e.g., the community staff, members are building extensive skills, resources as a result of the intervention).	The intervention contributes to a growing and evolving community and is an example and inspiration for others (e.g., intervention team has expanded program based on initial success; other First Nations, Inuit or Métis peoples are using the intervention as a model).	
Rationale/ Examples						
Criteria #5: **Partnership and Collaboration**	The degree to which the intervention is supported by other organizations or institutions within and/or external to community (federal, provincial, municipal government, NGOs, institutions). The emphasis is on collaborative approaches to addressing needs/issues. ***Funders are only counted as partners if they provide more than funding to the relationship.*	There are no collaborative relationships or partnerships associated with the intervention.	The intervention utilizes a collaborative approach which defines a strategy for involving partners or collaborators; however, there have been substantial challenges in implementing the plans or involving partners.	The intervention involves active partners and/or collaborators who are guided by a collaborative strategy; however, there is room for improvement in deepening the partnerships/ collaborative relationships (e.g., a few challenges have been identified with partnerships).	The intervention involves active partners and/or collaborators who are guided by a collaborative strategy, and these partnerships and/or collaborations are recognized (i.e., by the community) for their contribution to addressing needs/ issues (e.g., the identification of project champions may be an indication of the quality of relationships).	
Rationale/ Examples						

CRITERIA	DEFINITION	1	2	3	4	MORE INFO REQUIRED
Criteria #6: **Effectiveness**	The degree to which an intervention has achieved significant (substantive[6] or statistical) positive intended and/or unintended outcomes among target groups (e.g., program participants, communities, organizations, and/or partners).	Emerging data suggests positive outcomes among target groups, but reporting is preliminary or limited (i.e., the evidence is based on early stages of implementation and/or evidence is limited or difficult to verify)	Significant achievement (substantive[7] and/or statistical) of knowledge and /or awareness change among the target group(s). Limited partnership, networking and/or development of organizational capacity among the target group(s).	Significant achievement (substantive[8] and/or statistical) of positive outcomes (e.g., attitudes, intentions or values, building partnerships, networks, and developing organizational capacity) among the target group(s). Achievement of some positive behavior change outcomes however, changes may not yet be statistically or substantively significant among the target group(s).	Significant achievement (substantive[9] and/or statistical) of positive behavior change outcomes (e.g., personal or professional practice change, organizational/systems, and/or policy change) among target group(s).	
Rationale/ Examples *Include examples of all outcome types*						

[6] The term substantive significance is applied broadly to mean more than the quantitative effect size but inclusive of qualitative or practical considerations such as cultural, political, or economic significance. Stated another way the substantive significance refers to the degree to which the findings are significant within the community and context in which they are observed.

[7] Ibid 2

[8] Ibid 2

[9] Ibid 2

APPENDIX C: NEW ABORIGINAL INTERVENTIONS ON THE PORTAL

Aboriginal interventions on the Portal as of January 8, 2015, assessed using the new *Aboriginal Ways Tried and True* Scoring Rubric.

Caring for the Circle Within: Jackson Lake Land Based Healing Program for Women

Caring for the Circle Within is a residential land based healing program that blends Western clinical and First Nations healing approaches to support adults who are dealing with the impact of trauma (typically intergenerational trauma as a result of residential schools). It is expected that with this additional support, participants will have more positive interactions with their families and communities, gain knowledge and skills (traditional and mainstream) to apply to challenges of daily life. Three camps have been delivered 2 for women and 1 for men. Participants were typically struggling with addiction issues and/or incarceration.

Drop the Pop

Drop the Pop is an annual, month-long pan-territorial school-based iniaitiave that encourages youth to reduce their consumption of -sugar sweetened beverages and increase the consumption of healthy foods. Students create visual displays, particpate in special activities, receive awards and incentives to encourage kids to drop the pop. The initiative started in Nunavut in 2003, and in 2011 was replicated in the Yukon and the Northwest Territories. It has also been adapted by at least one FN community (James Bay Cree).

Hobbema Community Cadet Corps

A program in Hobbema Alberta that focuses on enhancing positive factors and reducing risk factors in youth. The program was developed and is run by RCMP officers, using a developmental assets framework. The program involves meetings, involvement in community events and other activities. The project saw mediocre participation but a clear increase in personal assets in at-risk youth and in external assets such as community support.

Journey to Wellness (J2W)

Journey to Wellness (J2W) is a 8 week school-based program for Aboriginal youth between the ages of 12 and 18 years aimed at supporting youth to develop healthy lifestyles while examining suicide risk and protective factors. Youth are engaged in weekly activities that focus on relationship building, problem solving, self esteem, facts and myths about suicide, networking, life planning.

Kahnawake School Diabetes Prevention Project (QB)

Community university partnership- school-based diabetes prevention program for 6–11 year olds; running since 1994; curriculum based health programming (10–45 minute lessons per grade) for grades 1–6 along with supplementary community-wide activities.

Kainai – Ever Active Schools

The Kinai Board of Education and Ever Active Schoolsare working together to understand how to improve health and wellness among youth in the community. The project has led to daily physical activity opportunities within the high school, community-wide active living days and other community awareness campaigns. A photo voice project has been used to document the project and the outcomes achieved to date. Students report better self-confidence, health and motivation.

Listening to One Another

An adaptation of the U.S developed Strengthening Families Program, followed by an Indigenous adaptation in the US with moderately positive results and by PHAC in 2011 for a number Aboriginal communities in Canada. This family-centred drug and alcohol abuse program includes 15 weekly experiential learning sessions with unique themes for 10–12 year old adolescents and their families. Findings from the US adaptation suggest a high retention rate for participating families relative to programs that have been culturally adapted, high levels of family attendance, and significant impact in youth behaviour.

Little Salmon Carmacks First Nation Greenhouse & Farm (Yukon)

The Little Salmon Carmacks First Nations started this community garden project in 2000. The garden produces fresh foods which are distributed within community with priority given to members with diabetes, pregnant and nursing mothers, and a local school. The program also provides several employment opportunities for community members. Noted outcomes include: high demand for the produce and increasing number of members with their own backyard gardens, source of pride and media attention. They have been approached by other communities to learn about the model and practices.

Makimautiksat Youth Wellness and Empowerment Camp (Nunavut)

A summer camp program developed out of 1.5 year consultation process with youth, parents community members and teachers in Nunavut. This 10-day land and community-based camp focuses on fostering wellness, positive Inuit identity, community-building and skill-building.

Nimi Icinohabi Program

This is an evidence-based substance abuse prevention program for Aboriginal children and youth (grades 3–9) reviewed and adapted by the Alexis Nakota Sioux to ensure that it incorporated their cultural beliefs, values, language, and visual images. The adapted program was delivered to students at Alexis Nakota Sioux Nation School and changes in student participants' knowledge, attitudes, refusal skills, and self-beliefs were measured. Benefits and challenges of adapting the program were documented.

Okichitaw Indigenous Martial Arts Program

A culturally based and developed martial arts program offered to urban Aboriginal adults since 1997. The program, developed by a George Lépine, is based on Cree combat maneuvers. The Okichitaw aims to empower students and strengthen mental and physical strength.

Reclaiming Our Ancestral Footsteps

A mental health promotion project for Mi'kmaq and Maliseet youth in Elsipogtog (Big Cove) First Nation in New Brunswick. It is a National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) project that consists of culture camps for youth 16-18 to learn their culture, language and traditions from Elders and other resource people, and also personal wellness and healing strategies. The camp has been very successful and was adapted into a community-run event after Big Cove lost NAYSPS funding.

Sandy Lake Health and Diabetes Project

A multifaceted diabetes prevention program implemented over the past 20 years in a remote fly-in First Nations community in northern Ontario. The intervention involves: a school-based diabetes curriculum for children in grades 3 and 4; a diabetes radio show; and community activities aimed at increasing awareness and prevention of diabetes. The program was developed and monitored through a collaborative partnership between the community and academic researchers.

Take A Kid Trapping/Harvesting

A land based program established in 2002 aims to provide Aboriginal school aged children with opportunities to participate in food harvesting activities and other traditional skills. The program is based on a need for younger generations to learn about and become able to trap. Each participating community is invited to apply for a cost-sharing program and adapt the programming to their own needs and traditions by incorporating local Elders and trappers. Children participate in camps and other activities where local community members teach students a number of traditional food based skills: building traps, hunting, trapping, preserving meat and other skills. In 2012, 2,400 youth in NWT participated in the program.

APPENDIX D: SYNOPSIS OF SOURCES CONSULTED ON "GOOD" PRACTICE IN ABORIGINAL CONTEXTS

Canadian Aboriginal AIDS Network(CAAN) "good practice"(CAAN, 2004)	• Community –based approaches • Holistic Care • Treatment and Support • Community Awareness • High-Risk Group for education and Counselling • STI Screening as Prevention • Harm Reduction for addictions • Healthy Sexuality • Sustainable funding, resources and advocacy
Australia National Institute of Health Research "good practice" (as cited in AHF, 2006)	• Needs identified by the community • Partnerships developed between Indigenous health workers and non Indigenous workers • Adequate resources and organizational support • Projects under the control of communities and Indigenous health workers • Outcomes identified • sustainability
Johnston Research Inc. Identification of Promising Practice in Physical Activity "Promising/Best Practice" (unpublished manuscript)	• Holistic approach grounded in culture • Traditional Healing • Blended Services • Community-centred/community-designed approaches • Recruitment, retention, capacity building • Prevention and promotion • Research and evaluation

Rethinking Nursing Best Practices with Aboriginal Communities: Informing Dialogue and Action (Smith et. al., 2010)	Surveyed 16 key informants from Aboriginal health and best practice fields and literature review. Literature: • Important to recognize multiple ways of knowing and a best practice approach integrates these different ways of knowing (Brant-Castellano, 2001; Dion-Stout and Kipling, 2001; Anderson, 2003; Smylie, 2004). • Indigenous knowledge is very important because it is this knowledge that reveals the values, principles and mores of the community (Alderete, 1996) • Evaluation needs to be informed by multiple perspectives including: clients, service providers, community members , partners • Best practices must be situated within the context of history, culture, needs and reality of a community • Findings of Interviews: • Use Indigenous Frameworks- rooted in culture, knowledge and context- value and use the knowledge that exists in the community will produce a practice that is more relevant - who is involved with developing the program?- Elders, community members • Build Capacity and Support Self Determination - does the program reflect community needs – have they been involved in planning it – how are partnerships working- is there equality • Ensure Cultural Safety – providing care from a perspective of understanding or trying to understand the cultural context of the individual.
NAHO Criteria(as cited in AHF, 2006)	• Impact • Sustainability • Responsiveness • Client focus, gender and social inclusion • Access, coordination and integration • Leadership, innovation, • Potential for replication, • health and policy • capacity for evaluation

Health Council of Canada (2011). Compendium of Promising Practice	Criteria used to assess practices in the Compendium (informal process) • acknowledged to positively advance Aboriginal Health status • inclusive of the interests and experiences of many • values and supported by relevant stakeholders • well-known/has a history of success • adaptive-recognizes community context • evaluated, ideally Feature of Promising Practices in the Compendium • Holistc approach • Focus on wellness not illness • Traditional knowledge and cultural practices • Coordinated access to a team of multidisciplinary front-line professionals • Community ownership and self determination • Collaboration and integration • Alignment of federal, provincial, territorial, and regional governments, together with Aboriginal leadership and communities • Stable funding • Evidence and accountability • Supportive education and training
Strengthening Urban Aboriginal Families: Exploring Promising Practices (Scott, 2013)	• Involve families by meaningfullyengaging them through representationon local boards or committees, or powerfully responding to their feedback or community initiative; • Cultivate a high degree of cultural competence or ability to functionally blend or work with traditional healing modalities • Develop and maintain sustainable partnerships that manage to overcome the jurisdictional barriers complicating service delivery for urban Aboriginal families; • Provide a centralized location for integrated service delivery; • Produce desired outcomes; • Emerge from a creative process where policies and protocols change to bettermeet client needs; • Be status blind (i.e., accepting of all Aboriginal people regardless of how they identify); • Be easily adapted to different contexts or cities; and • Be easily integrated with other family support services that may have a primary focus outside of family functioning (e.g., employment, education or housing)

APPENDIX E: EXPERT INTERVIEWEES

Dr. Alika Lafontaine
Vice President
Indigenous Physicians Association of Canada

Cassandra J. Opikokew
Knowledge Translation
Indigenous Peoples' Health Research Centre (IPHRC) [University of Regina]

Donna Atkinson
Manager
National Collaborating Centre for Aboriginal Health

Erin Corston
Health Director
Native Women's Association of Canada

Fiola Hart Wasakejic
Executive Director
Aboriginal Nurses Association of Canada (ANAC)

Kelly Patrick
Program Consultant
National Association of Friendship Centres (NAFC)

Dr. Lynn Lavalleé
Métis and a specialist in sports and recreation
Associate Director, Undergraduate Program & Associate Professor
Ryerson University

Peggy Lafleur
Director
Nechi Training, Research and Health Promotions Institute

Paul Bélanger
Assistant Director
Canadian Institutes of Health Research
Institute of Aboriginal Peoples' Health

Sara Fryer
Project Manager
Aboriginal Healing Foundation

APPENDIX F: INTERVIEW GUIDE

Aboriginal Health Best Practices Web Portal Research Project

The Aboriginal Health Best Practices project will bring Aboriginal program practices to light on a global scale using a Web Portal. This research project will collaborate with and consult with Aboriginal research and program delivery experts through our Working Group, telephone interviews, and in-person meetings in communities. We will ask these experts to help us refine our thinking on criteria which will rigorously identify example programs using an Indigenous lens that respects Indigenous ways of knowing. From these conversations we will develop a Health Best Practices Aboriginal Framework and from there systematically identify potential example programs. We are contacting you at this time to gain insights from your knowledge on: 1) what are the key community member needs in Mental Wellness and Health Weights promotion programming; 2) What understandings on Aboriginal ways of knowing and being need to be included when assessing if a program is a best practice; and 3) what example programs would you recommend for us to consider for the Aboriginal health section on the Web Portal.

The Aboriginal section will be added to the current Agency website titled "**Canadian Best Practices Portal**," at cbpp-pcpe.phac-aspc.gc.ca. The Portal, driven by the federal government, provides you with resources and solutions to plan programs for promoting health and preventing diseases in your community.

Your input is confidential and will be utilized to directly inform our thinking and the approaches we utilize for this project. You can stop me at any time to ask questions. We can also stop our conversation at any time.

Do you consent to share your knowledge and expertise as I just explained (above)?

If you have any further questions please feel free to contact Nina I Jetha, Best Practices Portal Manager, Public Health Agency of Canada at (613) 952-7608 or Johnston Research Inc., the First Nations consulting firm that is carrying out the research at 905-889-4430 or 1-866-885-9940.

INTERVIEW QUESTIONS

ID Date

Q1. We have adopted two names to represent new Web Portal content areas specific to Aboriginal health issues: "Mental Wellness" and "Healthy Weights"; do you agree this vocabulary suits your thinking on what mental health and obesity prevention programming is trying to address?

Q2. [a] How would you define Mental Wellness?
[b] What priorities in Mental Wellness should be featured on the Web Portal?

Q3. [a] How would you define Healthy Weights?
[b] What priorities in Healthy Weights should be featured on the Web Portal?

Q4. What are some of the considerations that you believe support effective Mental Wellness programming for Aboriginal people? (e.g., process, community, culture, collaboration)

Q5. What are some of the considerations that you believe support effective Healthy Weights programming for Aboriginal people? (e.g., process, community, culture, collaboration)

Q6. What example programs would you recommend for the Aboriginal Web Portal?

Q7. What do you think would be the best methods for sharing the Web Portal, so that it could reach as many community health professionals as possible?

Q8. Would you like to add anything else?